State of California
Division of Workers' Compensation Medical Unit
P.O. Box 71010
Oakland, CA 94612

QME DISCLOSURE OF SPECIFIED FINANCIAL INTERESTS ("SFI Form 124" Attachment to QME Form 100, 103 & 104)

Name	Professional License No.

Business Address	QME No. (if applicable)

Business Telephone No.	Fax No.

PARTNERSHIP INTERESTS (Attached continuation sheets of needed)

Name of Business Entity in which have limited or full partnership interest:

Address of Business Entity:

Names of partners who are physicians at same location (MD, DO, DC, OD, DPM, DDS, PhD or L.Ac.):

INTERESTS OF 5% OR MORE IN MEDICAL PRACTICE, MEDICAL GROUP OR OTHER MEDICAL OR MEDICAL/LEGAL BUSINESS ENTITY IN CALIFORNIA WORKERS' COMPENSATION SYSTEM

Name of Medical Practice/Group/Business Entity:

Address of Business Entity:

Names of participating physicians at same location (MD, DO, DC, OD, DPM, DDS, PhD or L.Ac.):

RECEIPT OF 5% OR MORE OF PROFITS FROM MEDICAL PRACTICE, MEDICAL GROUP OR OTHER MEDICAL OR MEDICAL/LEGAL BUSINESS ENTITY IN CALIFORNIA WORKERS' COMPENSATION SYSTEM

Name of Medical Practice/Group/Business Entity:

Address of Business Entity:

Names of participating physicians at same location (MD, DO, DC, OD, DPM, DDS, PhD or L.Ac.):

I declare under penalty of perjury that the foregoing information is current, complete and accurate to the best of my knowledge. Signed this _____ day of _____, 20____ at _____, California.

Print name_____ **Signature:**_____